COVERRx
COVER TENNESSEE

EXPRESS SCRIPTS®

Express Scripts Specialty Distribution Services, Inc.
P. O. Box 66979, St. Louis, MO 63166-6979

All fields must be completed (unless noted as optional) or application will be returned.

Applicant Information

Last Name	First Name	MI	Gender ❑ M ❑ F	Date of Birth

Social Security Number	# of People in Household	Yearly Household Income (Do not leave blank)	Phone Number (Write N/A if you do not have a phone) ( )

Home Address	City	State	Zip Code

Mailing Address (if different from above)	City	State	Zip Code

Race (optional):
❑ Black: Hispanic or Non-Hispanic
❑ White: Hispanic or Non-Hispanic
❑ Asian / Pacific Islander
❑ American Indian / Alaskan
❑ Mixed Ethnicity
❑ Other _____

Language Spoken (optional):
❑ English
❑ Spanish
❑ Other _____

❑ Yes	❑ No	Are you a U.S. citizen or qualified legal alien?
❑ Yes	❑ No	Have you lived in Tennessee for at least the last six months?
❑ Yes	❑ No	Do you have health insurance (including TennCare)?
❑ Yes	❑ No	Do you have any prescription drug coverage other than CoverRx? This includes Medicare, TennCare or drug coverage provided by your employer. (Discount drug programs or patient assistance programs providing free or low-cost medications do not count.)
❑ Yes	❑ No	Do you have Medicare (Any Part including A, B, C, or D)?
❑ Yes	❑ No	Are you homeless or living in a shelter? (optional)
❑ Yes	❑ No	Are you employed (including self-employed)? (optional)
❑ Yes	❑ No	Do you work 20 hours or more in a seven day work week? (optional)

Terms and Conditions

While you are in CoverRx, you must follow the program rules. By signing the front of this form, you agree that:

You will pay your co-pay for each prescription filled.

You will notify CoverRx when:

- You move to a new address
- Your household income changes significantly
- The number of people in your household changes
- You have other prescription drug coverage

Event Code
460

You will help with any investigations. CoverRx may ask you for proof of your household income. CoverRx may also ask you to provide proof that you live in Tennessee and/or that you are a U.S. citizen or qualified alien. You agree to provide this information to CoverRx. If you do not help, then you could lose your pharmacy assistance.

You allow CoverRx to get information about you. I understand that I have certain privacy rights with respect to my medical information under the Health Insurance Portability and Accountability Act (HIPAA), CFR Parts 160 and 164 ("Privacy Rule"). The Privacy Rule permits CoverRx to use and disclose my protected health information for purposes of treatment, payment and health care operations, including determining my eligibility for benefits.

You can report fraud or abuse. If you suspect someone of fraud or abuse please call Express Scripts at 1-888-560-2649

Authorization: I want to apply for CoverRx pharmacy assistance. By signing below, I certify that the information contained in the application is true and accurate. I know that if I give any false information, I may be breaking the law. I know that CoverRx will check my information. I agree to help with any investigations. I also agree to follow the rules for the CoverRx program. I have read and understand these rules, which are on the back of this form.

Signature: _____ Date: _____

CoverRx does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, or national origin. **If you have a complaint regarding discrimination, please call 1-866-576-0029 or 615-741-4517.**

Eligibility

To be eligible to participate in CoverRx, you must meet the following eligibility guidelines:

- Age 19 through 64
- Household income must be at or below the income guidelines listed below
- U.S. citizen or qualified alien
- Cannot have Medicare (Any Part including A, B, C or D)
- Tennessee resident for at least the last six months
- No prescription drug coverage including Medicare, TennCare, or employer-sponsored drug coverage. (Discount drug programs or patient assistance programs providing free or low cost medications do not count.)

How Much You Will Have to Pay

If you are enrolled, CoverRx will help you pay for up to five prescriptions each month, plus diabetic supplies and insulin. You must pay a small co-payment for your first five prescriptions each month. (Note: A 90-day prescription counts as three 30-day prescriptions.) The co-payment amount for the first five prescriptions is based on your household income. Co-pay ranges are listed in the table to the right. If enrolled, your exact co-payments will be included in your welcome packet.

Co-payments are subject to change.

Co-Payments (for each medication, up to five prescriptions per month)	
Drugs on the CoverRx list	Generic Drugs: 30 day = $3 - $8 *90 day = $3 - $16 Brand Drugs / Insulin / Diabetic Supplies: 30 day (or up to covered limits = $5 - $12 *90-day supplies are only available through mail order and those local retail pharmacies that have chosen to participate. Before you fill your prescription, check with your pharmacy to see if the 90-day supply is available at that location. A 90 day supply is not available for covered brand drugs and covered insulin
Drugs NOT on the CoverRx list and/or ALL prescriptions after the five prescription per month limit	Full price (price varies by drug), plus any pharmacy discounts available

- You must pay the full amount for all prescriptions above the monthly (5) prescription limit. Pharmacy discounts are available to help you with the cost of these medications.
- You can purchase your prescriptions at participating local community retail pharmacies and mail order pharmacies.
- Upon enrollment in CoverRx, a welcome packet will be sent to you with information about how to use the program.

Income Guidelines

To qualify for the CoverRx program, your yearly household income must be at or below the levels listed in the table to the right.

The yearly household incomes listed are for 2009. Amounts are subject to change each year.

Persons in Household	Yearly Household Income
1	$27,075
2	$36,425
3	$45,775
4	$55,125
5	$64,475
6	$73,825
7	$83,175
8	$92,525

Contact Information

Mail completed form to: Tennessee CoverRx
Express Scripts Specialty Distribution Services, Inc.
P.O. Box 66979,
St. Louis, MO 63166-6979

For questions about enrolling in CoverRx: 1-888-560-2649

Definitions

"Discount" means a price reduction offered to participants for certain prescriptions.

"Household Income" is the combined income of all household members 18 years old and over who maintain a single economic unit, as well as any income received by the household for the personal medical and other obligations of the participant(s) in the household.

"Household" is comprised of all persons living in the same residence maintaining a single economic unit.

"Qualified alien" means that you are not a U.S. citizen, but you live in the United States legally. To be a qualified alien, you must also meet other conditions. These conditions are defined in the federal law at 8 U.S.C. § 1622(b). If you are not a U.S. citizen or qualified alien, then you cannot enroll in CoverRx.

CoverRx is managed by Express Scripts, Inc. (ESI), which among other things, owns and operates a mail order pharmacy. ESI does not accept returns of unused medicine, and fees are nonrefundable once ESI received your valid prescription. ESI will send your medicines to the address you choose. You are responsible for the package once it arrives. 9/09